Bartz Chiropractic
1316 SW 4th Terrace, Suite #102
Cape Coral, FL 33991

CONFIDENTIAL PATIENT CASE HISTORY

Dear Patient:

Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily we will not accept your case. ***Thank you.***

Date_____

Name_____ **Primary Care Physician**_____
First Middle Last
Address_____ **Employer**_____
City_____ **State**_____ **Zip**_____ **Referred by**_____
Soc Sec #_____ **Cell Phone**_____ **Spouse's Name**_____
Home Phone_____ **Marital Status:** M S W D
Birthdate _____ **Age**_____ **Gender:** M F **# of Children** _____ **Email**_____

HEALTH INFORMATION

What is your major complaint?			
How long have you had this condition?		**Have you had this or similar conditions in the past?**	**Yes No**
Have you had previous chiropractic care?	**Yes No**	**Is condition getting progressively worse?**	**Yes No Constant Comes and goes**

Other doctors who treated this condition	**Name**	**Address**

What activities aggravate your condition?	
Is this condition interfering with your:	**Work Sleep Daily Routine Other**

List surgical operations and year	**Year**	**Operation**

Prescriptions you now take	**Dosage**	**Prescription**	**Reason**

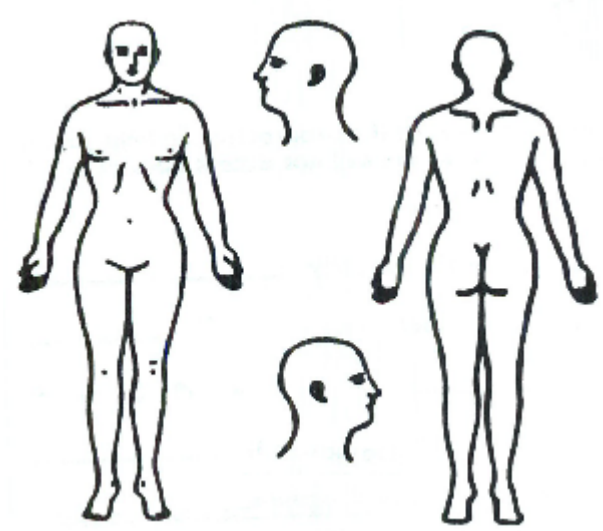
Age of mattress _____ ❑ **Comfortable** ❑ **Uncomfortable**

Are you wearing? ❑ **Heel lifts** ❑ **Sole lifts** ❑ **Inner soles** ❑ **Arch supports**

Have you been in an auto accident?	**When**	**Describe**
	❑ **None**	
	❑ **Past year**	
	❑ **Past 5 years**	
	❑ **Over 5 years**	

Have you had any other personal injury or accident?	**When**	**Describe**
	❑ **None**	
	❑ **Past year**	
	❑ **Past 5 years**	
	❑ **Over 5 years**	

Please mark your areas of pain on the figures below.



Date of last physical exam_____

Height_____ **Weight**_____

Have you ever suffered from:

- ❑ **Dizziness**
- ❑ **Backaches**
- ❑ **Heart trouble**
- ❑ **Diabetes**
- ❑ **Arthritis**
- ❑ **Headaches**
- ❑ **Asthma**
- ❑ **Neuritis**
- ❑ **Digestive disorders**
- ❑ **Nervousness**
- ❑ **Sinus trouble**
- ❑ **Neck pain**
- ❑ **Allergy/adverse reaction**□

INSURANCE INFORMATION

Is your condition due to an auto accident or job-related injury?		**Yes No**	
Do you have health insurance?	**Policy Number**	**Name of Company**	
No Yes			
Name and Address of Employer of Cardholder			
Date of Birth of Cardholder	**Name of Cardholder**		
Are you covered by Medicare? No Yes	**If yes, Health Insurance Number**		

I understand and agree that health and accident polices are an arrangement between an insurance carrier and myself. Furthermore, I understand that Bartz Chiropractic will prepare any necessary report and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Bartz Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature_____ **Date**_____

Guardian or Spouse's Signature_____ **Date**_____

Doctor's Signature_____ **Date**_____

FAMILY HEALTH INFORMATION

**(Many health problems are the result of hereditary spinal weaknesses;
thus information about your family members will give us a better picture of your total health picture.)**

Name	Relation	Past and Present Health Problems

Bartz Chiropractic, LLC

PATIENT CONSENT
FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone, or by e-mail.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for *all future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____	_____
Name of Patient/Individual (Please print)	Signature of Patient/Individual
_____	_____
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor)	Relationship to Patient
_____	_____
Date Signed	Witness

Bartz Chiropractic

"Serving your Mid-Cape Chiropractic Needs"

Informed Consent to Chiropractic Care

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to a stroke.

Prior to receiving chiropractic care at Bartz Chiropractic, a health history and physical examination will be completed. These procedures are performed by members of our faculty and are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations deemed necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment. I understand that all Doctors and Chiropractic Assistants at Bartz Chiropractic could be involved in my care. I also understand that my condition and treatment could be used for training and/or educational purposes with my consent. My name and other personal identifying information will be kept confidential.

_____	_____
Patient Name (printed)	Relationship to patient
_____	_____
Patient or legal Guardian Signature	Date
_____	_____
Witness Signature	Date

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